STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165257	A. BUILDING _____ B. WING _____ 9/21/12 MW	C 08/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE SKILLED NURSING & R	1915 SOUTH 18TH STREET CENTERVILLE, IA 52544

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaints 39991-C, 40100-C and incident 40185-I were investigated August 1-27, 2012. The following deficiencies relate to the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. Correction date 9-5-12	F 000		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The following deficiency relates to complaint 39991-C: Based on record review and staff and family interviews, the facility failed to provide an accurate assessment and timely intervention when Resident #1 had problems with clearing throat and appeared distressed by a family member. The resident displayed adverse symptoms and staff did not assess the resident and provide timely suctioning as ordered by the physician. The sample consisted of 4 residents and the facility identified a census of 57 residents.	F 309	HEALTH FACILITIES SEP 18 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Kelley — TITLE: Administrator — (X6) DATE: 9-13-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 1	F 309		

Findings include:

1. Resident #1 had an MDS (Minimum Data Set) assessment with a reference date of 5/18/12 which reflected the resident had impaired short and long term memory deficits and severely impaired cognitive skills for daily decision making. The MDS identified Resident #1's diagnosis included end stage renal disease, cerebral vascular accident, diabetes mellitus type II, dementia, atrial fibrillation, congestive heart failure and anxiety.

A physician communication form dated 6/5/12 indicated the facility requested a physician order for the resident to receive suctioning due to large amounts of mucous.
The Treatment Administration Record (TAR) for June 2012 indicated the last recorded time the suctioning performed was on 6/8/12 by Staff C.
The Nurse's Notes dated 6/8/12 at 10:40 a.m. and written by Staff C, identified Resident #1 with a loose wet cough and staff suctioned thick clear phlegm from the resident.

In an interview on 8/1/12 at 12:14 p.m. FM 1 (family member #1) indicated she arrived to the facility at 7:30 a.m. on 6/22/12 and heard Resident #1 yelling out the family member ' s name. FM1 entered the resident ' s room and noticed food debris on the resident ' s lips. The resident appeared to be in distress as he/she was trying to clear his/her throat. FM 1 left the room and found Staff A (Licensed Practical Nurse-LPN) and informed the staff person that Resident #1 was in distress. Staff A came to the room, but noted she had eight other residents ahead of Resident #1. Staff A observed Resident #1 and

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F 309	Continued From page 2	F 309		

told FM 1 he/she was pocketing food (keeping food in checks and not swallowing). Staff A attempted to wipe Resident #1's mouth. Staff A then left the room without attempting to suction Resident #1. FM 1 then left the room and found Staff F (Social Worker) and inquired as to needing oral swabs (Toothettes) to wipe the inside of the resident ' s mouth). Staff F gave FM 1 the keys to the storage area and FM 1 obtained several swabs, returned the keys to Staff F and returned to Resident #1's room. FM 1 stated she was not out of Resident #1's room for more than 1 to 2 minutes. FM 1 stated that once back in the room, she was afraid of trying to wipe out Resident #1's mouth in fear she may choke the resident. Minutes later FM 1's sister, family member #2 (FM 2) entered the room and witnessed Resident #1 in distress. FM 2 informed FM1 she would find a nurse and she left the room. Minutes later Staff B (Certified Nurse Aide, CNA) entered the room and FM 1 indicated Resident #1 needed suctioned and she was unable to get Staff A to help. Together Staff B and FM 1 got Resident #1 up into his/her geriatric chair. Staff B attempted to get Resident #1 to cough and expel anything in throat, but was unsuccessful. Staff B then propelled Resident #1 to the assisted dining room area as FM 1 remained in the bedroom. Within minutes Resident #1 was propelled back into the bedroom accompanied by Staff C (Registered nurse, RN) and Staff D (Certified Nurse Aide). Staff C walked to the suction machine and stated, "It's not even put together". Someone (unknown) obtains the container and supplies as Staff C then attempts to get the suction machine together. FM 1 was saying "hurry". FM 1 indicated Staff C had begun suctioning Resident #1 for about two

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F 309	Continued From page 3	F 309		

minutes when instructed by Staff C to get Staff G (Assistant Director of Nursing). FM 1 left the room and told Staff G, who was sitting in her office, that Resident #1 needed her now. Staff G responded to Resident #1's room. Staff G placed a stethoscope on Resident #1's chest while Staff C continued to suction. Staff G looked up at FM 1 and FM 1 stated, "Is that it?" Staff G responded, "Yeah, that's it".

The time Card for FM 1 identified FM 1 clocked in for work at 7:30 a.m. on 6/22/12.

On 8/2/12 at 1:23 p.m. Staff A (Licensed Practical Nurse, LPN) was interviewed and stated on the morning of 6/22/12, she was approached by FM 1 and asked to come to Resident #1's room. Staff A and FM 1 walked to Resident #1's room. FM 1 told Staff A that Resident #1 had stuff in his/her mouth and apple sauce on his/her lips and may need suctioned. Staff A saw the dried apple sauce on Resident #1's face and asked Resident #1 to open his/her mouth. Staff A saw nothing in the Resident #1's mouth. Staff A looked for oral swabs in the room and saw none. The nurse again asked Resident #1 to open his/her mouth, but this time the resident refused. FM 1 told Staff A to go on, she would get Staff C. Resident #1 will open his/her mouth for Staff C. Staff A left the room and walked directly to the supply room and obtained some swabs and returned to Resident #1's room (less than 1 minute). Staff A then swabbed Resident #1's mouth out and noted nothing was observed on the swab. Staff A noted Resident #1's respirations were even and unlabored and he/she was not in any distress. Staff A informed Resident #1 that an aide would be in soon to get him/her up for breakfast and

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F 309	Continued From page 4	F 309		

Resident #1 responded, "okay". Staff A indicated FM 1 was not in the room during this time. Staff A stated she retumed to the floor and continued assisting others with getting residents up for breakfast. Staff A stated at around 8:15 a.m. she entered the assisted dining room to administer medications. Staff A heard a "rattling" sound and Staff C indicated it was Resident #1 and she was taking Resident #1 back to his/her room to try and suction. Staff A remained in the assisted dining room as Staff C took Resident #1 to his/her room. Staff A indicated FM 1 never made any statements about Resident #1 making sounds, being in pain or discomfort or of having any breathing problems.

On 8/1/12 at 12:59 p.m. FM 2 (family member #2) was interviewed and stated on the morning of 6/22/12, she was in the lobby and could hear Resident #1 "gurgling". FM 1 sought out Staff C, who was assisting a resident into the dining room and told Staff C that Resident #1 needed suctioned now. FM 2 stated Staff C did not respond and continued to help residents. FM 2 stated she retumed to the laundry room.

On 8/1/12 at 11:20 a.m. Staff B (Certified Nurse Aide) was interviewed and stated on the morning of 6/22/12, she heard Resident #1 call out for FM 1 about three times and could tell Resident #1 needed help coughing up something. Staff B responded to Resident #1's room and FM 1 indicated she had tried getting Staff A (LPN), but Staff A didn't come. FM 1 wanted to get help from another nurse. Together Staff B and FM 1 got Resident #1 up into his/her geriatric chair. Staff B then preceded to try and get Resident #1 to cough up or clear his/her throat for about 1-2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165257	A. BUILDING _____ B. WING _____	C 08/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE SKILLED NURSING & R	1915 SOUTH 18TH STREET CENTERVILLE, IA 52544

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F 309	Continued From page 5	F 309		

minutes. Staff B was unsuccessful with getting Resident #1 to clear his/her throat so she took Resident #1 to the assisted dining room to be seen by Staff C (RN). Staff B indicated Resident #1 was "gurgling" as she arrived to the assisted dining room. Staff B informed Staff C that she was unable to get Resident #1 to cough up anything and was instructed by Staff C to try and give him/her a sip of tea. Staff B indicated Resident #1 took a sip but remained in distress. Within 1-2 minutes of being in the assisted dining room, Staff C and Staff D (CNA) took Resident #1 back to his/her room. Staff B stated from the very beginning that morning she felt Resident #1 was in need of being suctioned. In a statement written for the facility on 6/22/12, Staff B indicated she had sent FM 1 to get some swabs and FM 1 returned with 6 swabs. Staff B attempted to clean Resident #1's mouth and obtained a little amount.

On 8/6/12 at 11:05 a.m. Staff C (Registered Nurse, RN) was interviewed and stated on 6/22/12 at around 7:00 a.m. she went into Resident #1's room to check for safety alarms. Resident #1 was in bed resting quietly without any signs or symptoms of discomfort. Staff C stated later that morning she was approached by FM 2 while working in Hall 1. FM 2 told her that Resident #1 was in need of suctioning and Staff A wouldn't help. Staff C stated she assumed Staff A, who was assigned to Resident #1, would get her if she needed help. Staff C stated at around 8:15 a.m. Resident #1 was brought into the assisted dining room by Staff B (CNA). Resident #1 was alert but gurgling. Staff B attempted to get him/her to cough up the phlegm without success. Staff C instructed Staff B to hold the food, but try to get Resident #1 a sip of tea.

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	165257	A. BUILDING _____ B. WING _____	C 08/27/2012

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GOLDEN AGE SKILLED NURSING & R	1915 SOUTH 18TH STREET CENTERVILLE, IA 52544

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F 309	Continued From page 6	F 309		

Within 2-3 minutes as the gurgling persisted, Staff A entered the assisted dining room and Staff C and Staff D (CNA) took Resident #1 to his/her room. The suction machine in the room was not set up for immediate use. Staff C had to leave the room to obtain a canister and returned to the room to find there was no tubing. Staff C went back to the supply room and obtained tubing. While setting up the canister and tubing, Resident #1 took two deep breathes and then stopped breathing. FM 1 left the room and got Staff G (ADON). Staff G entered the room and checked for a heartbeat and found none.

On 8/2/12 at 2:40 p.m. Staff D (Certified Nurse Aide, CNA) stated on 6/22/12 at around 8:15 a.m. she was in the assisted dining room assisting residents with eating when Resident #1 was propelled into the assisted dining room by Staff B (CNA). Staff D stated she heard Resident #1 choking before he/she ever got into the assisted dining room. Resident #1 sounded like he/she was drowning. Staff D immediately questioned what was happening and Staff B indicated Resident #1 was pocketing. Staff D stated that was not pocketing and stated she would find someone to help. Staff C (RN) who was also in the assisted dining room stated she would help or Staff A (LPN) could help. At that time Staff A entered the assisted dining room. Staff D instructed Staff A to remain in the assisted dining room and Staff C and Staff D took Resident #1 to his/her room to be suctioned. Staff D stated Resident #1 was already turning gray as they left the assisted dining room. FM 1 met Staff C and Staff D in the main lobby and followed them into the Resident #1's room. As they prepared to suction the staff discovered not all the needed

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	165257	A. BUILDING _____ B. WING _____	C 08/27/2012

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GOLDEN AGE SKILLED NURSING & R	1915 SOUTH 18TH STREET CENTERVILLE, IA 52544

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F 309	Continued From page 7	F 309		

items were in the room. Staff C and Staff D left the room to get the needed supplies as FM 1 remained with Resident #1. Upon returning, Resident #1 was turning even grayer and Resident #1 was stating, "I'm sick, I'm sick, I'm sick". Staff C continued to work on the suction machine then proceeded to suction him/her, but it was too late. By this time Staff G (ADON), FM 1 and FM 2 were all in the room and Staff D left. Staff D indicated it was probably 5-7 minutes from the time she heard Resident #1 drowning to when he/she passed away.

On 8/7/12 at 11:20 a.m. Staff E (Certified Nurse Aide, CNA) was interviewed and stated on the morning of 6/22/12, she was in the assisted dining room assisting with feeding residents when Staff B (CNA) brought Resident #1 into the assisted dining room. Resident #1 sounded like he/she was underwater when she talked. Staff D (CNA) asked Staff B if Staff A (LPN) had suctioned Resident #1. Staff B stated Staff A said she tried suctioning but she felt Resident #1 was pocketing saliva/mucous. Staff C (RN) instructed Staff B to try and give Resident #1 a drink of tea to get the food down, if he/she was pocketing. Staff E stated that Resident #1 did not drink anything. Staff E stated Staff C and Staff D had to wait until Staff A arrived to the assisted dining room before they could take Resident #1 back to his/her room to try to suction him/her. Within 3 minutes, Staff A walked into the assisted dining room and Staff C and Staff D took Resident #1 back to his/her room. Staff E stated after Resident #1 was taken back to his/her room, she asked Staff A if she had suctioned Resident #1 and Staff A stated she had tried, but Resident #1 was just pocketing the mucous.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165257	A. BUILDING _____ B. WING _____	C 08/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 8	F 309		

On 8/8/12 at 3:30 p.m. Staff F (Social Services/Licensed Practical Nurse) stated she was working in Hall 2 performing care duties on the morning of 6/22/12. FM 1 approached Staff F and asked who the nurse was for Hall 3. Staff F stated it was Staff A. FM 1 asked if she could get into the supply room for swabs because she thought Resident #1 needed suctioned. FM 1 was given the supply room keys, obtained the swabs and returned the keys within one minute, then took off to find Staff A. Staff F continued working. Several minutes later Staff F was standing in the dining room when Resident #1 was propelled by Staff C (RN) towards his/her room. Resident #1 was gurgling and Staff F asked if Staff C needed any help. Staff C indicated they were taking Resident #1 back to his/her room to suction him/her. Staff F continued to help residents from the dining room and approximately 5 minutes later was at the front of Hall 3 when Staff C yell get Staff G. Staff F stated, "I'm right here, can I help". Staff F entered Resident #1's room and walked to Resident #1 who was in his/her geriatric chair facing the window. Staff C was working with the suctioning machine. Resident #1 was blue around his/her mouth and Staff F asked if he/she was okay. Resident #1 did not answer, so Staff F did a sternal rub and got no pain response. Staff F felt for a pulse and asked if someone could get her a stethoscope. An aide returned with a stethoscope and upon listening Resident #1 was without a heartbeat. At this same time Staff G (ADON) walked in and took the stethoscope and checked for a heartbeat as well. Resident #1 was without a heartbeat.

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	165257	A. BUILDING _____ B. WING _____	C 08/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE SKILLED NURSING & R	1915 SOUTH 18TH STREET CENTERVILLE, IA 52544

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F 309	Continued From page 9	F 309		

On 8/6/12 at 1:35 p.m. Staff G (Assistant Director of Nursing, ADON) was interviewed and stated she arrived to work at 8:15 a.m. on 6/22/12 and before she could even sit down, FM 1 approached her and said Resident #1 was in need of suctioning. Staff G accompanied FM 1 and walked to Resident #1's room. Upon entering, Resident #1 was in his/her geriatric chair with his/her back facing the door. Staff C, D and F were in the room. Staff G looked at Resident #1 as he/she took two deep breathes. Staff C opened a suction tubing package and Staff F was listening to Resident #1's chest. Staff F handed Staff G the stethoscope and Staff G listened for an apical pulse for about one minute. Staff C began suctioning Resident #1's mouth and got a scant amount of cloudy white fluid Staff G felt for a carotid pulse for about one minute with no heartbeat or respirations detected. Staff G looked up at FM 1 and stated, "He's/She's gone". Staff D stated she had clocked in that morning at 8:15 a.m. and believed Resident #1 was pronounced dead by her at approximately 8:20 a.m.

The time card for Staff G confirmed Staff G clocked in for work at 8:15 a.m. on 6/22/12.

On 8/7/12 at 11:10 a.m. Staff H (Certified Nurse Aide, CNA) stated she was working the day shift on 6/22/12 and assigned Hall 2. Staff H stated she worked with Staff A (LPN) getting residents up when FM 1 came down the hall and informed Staff A that Resident #1 needed suctioned. Staff A went with FM 1 and Staff H continued working with residents living on Hall 2.

On 8/6/12 at 2:20 p.m. Staff I (Minimum Data Set

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165257	A. BUILDING _____ B. WING _____	C 08/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE SKILLED NURSING & R	1915 SOUTH 18TH STREET CENTERVILLE, IA 52544

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F 309	Continued From page 10	F 309		

Coordinator/Licensed practical nurse) stated she was working the morning of 6/22/12 when Staff D approached her asking where she could find suction tubing, noting the one they are using isn't working. Staff I instructed Staff D to go to the storage room to get it. Staff I then walked to Resident #1's room to ask specifically what was needed. Staff G and Staff C was in the room and Staff C was atternpting to suction Resident #1. Staff D came into the room with the equipment needed and Staff I left the room.

On 8/8/12 at 10:00 a.m. Staff J (Licensed Practical Nurse, LPN) was interviewed and stated she was working the morning of 6/22/12 on Halls 1 and 4. Staff J stated she had no physical contact with Resident #1 that day or of having any knowledge of Resident #1 being in distress until Staff G (ADON) arrived.

On 8/7/12 at 10:55 a.m. Staff K (Administrator) was interviewed and stated she arrived to the facility around 7:00 a.m. on 6/22/12 and was monitoring staff getting residents up for breakfast. At around 7:15 a.m. Staff K saw Resident #1 resting in bed and without any indication of being in distress. At around 8:15 a.m. Staff K was outside when Staff G (ADON) arrived. Staff K spoke to Staff G briefly before Staff G entered the facility. Moments later Staff K went into the facility and was sitting at the nurse's station when Staff D (CNA) told Staff K she needed to go to Resident #1's room. Staff K responded immediately (8:18 a.m.) Upon entering the room Staff K witnessed Staff C attempting to suction Resident #1 and Staff G pronouncing Resident #1's death.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165257	A. BUILDING _____ B. WING _____	C 08/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 11 In an interview 8/6/12 at 6:55 p.m. Staff L (Licensed Practical Nurse, LPN) was interviewed and stated at times Resident #1 would not completely swallow foods or medication and he/she would require suctioning. Resident #1 would also have oral secretions and would sound gurgled. Suctioning was effective at clearing Resident #1's airways during these times. Note: At the time of the complaint investigation, the complaint was coded at a "J", immediate and serious jeopardy. By 8/8/2012 the facility had abated the situation and adequately addressed the jeopardy and the grid placement was lowered to the "D" level. The facility had educated staff for proper assessment for a resident with a significant change of condition. The facility began checking suction machines each day. Suction machines are now fully equipped and ready for use. The nurses were educated and demonstrated the skills for proper oral suction machine use. As of the 8/8/2012 exit conference, the facility continued to need to: . Continue to educate nursing staff about proper assessment and timely interventions when a resident has a significant change of condition and requires oral suctioning. . Continue to monitor and ensure the nurses can perform proper tecniques for oral suctioning. . Continue to monitor each day that the suction machines are checked, equiped and ready for use.	F 309		
F 354 SS=D	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON	F 354		

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	165257	A. BUILDING _____ B. WING _____	C 08/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE SKILLED NURSING & R	1915 SOUTH 18TH STREET CENTERVILLE, IA 52544

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F 354	Continued From page 12 Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide registered nurse coverage for 8 consecutive hours a day, seven days a week as required. The facility census during the extended survey consisted of 59 residents. Findings include: 1. Review of the August 2012 schedule for R.N. (registered nurse) coverage revealed on 8/23/12 all R.N. coverage marked off the schedule. The schedule documented an "X" over the 6 A.M. to 4 P.M. shift where a staff registered nurse would have worked. A time clock readout for 08/23/2012 revealed the nursing department coverage for a registered nurse consisted of 09:45 a.m. to 1:45 P.M.. A four hour period of time. No other registered	F 354		

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F 354	Continued From page 13 nurse coverage could be found on the time clock. In an interview on 08/27/2012 at 11:00 A.M. and 12:10 P.M., Staff B (Director of Nursing) agreed the August 23, 2012 nursing schedule failed to show R.N. coverage. At 12:10 P.M., she verbalized being in the facility from 3:30 P.M. until 9:30 P.M. on August 23, 2012. The DON admitted no documentation could be found to confirm she worked on 08/23/2012 because she is salaried. In an interview on 08/27/2012 at 12:10 P.M., Staff C (Nurse Consultant/R.N.) verbalized being in the facility on 08/23/2012. On 08/27/2012 at 1:30 P.M., Staff C (Nurse Consultant/R.N.) produced a handwritten copy of a bill coverage submitted to the facility, dated 08/23/2012. The nurse consultant confirmed the facility did not have a waiver for R.N. coverage.	F 354		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: The following deficiency relates to complaint 39991-C: Based on (2) staff interviews and family interview, the facility failed to maintain patient care equipment (suction machine) in an immediately usable and operating condition for 1 of 4	F 456		

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F 456	Continued From page 14	F 456		

residents reviewed (Resident #1). The facility reported census was 57.

Findings include:

1. According to Resident #1's Minimum Data Set (MDS) with assessment reference date of 5/18/12, Resident #1 was identified with impaired short and long term memory deficits and severely impaired cognitive skills for daily decision making. Resident #1 required extensive assistance with physical assist of two staff with bed mobility, transfers, dressing, eating, bathing and personal hygiene needs. Resident #1's diagnosis included end stage renal disease, cerebral vascular accident, diabetes mellitus type II, dementia, atrial fibrillation, congestive heart failure and anxiety.

A Physician Communication form dated 6/5/12 indicated a request for suction as needed due to large amounts of mucous.

Treatment Administration Record for June 2012 indicated last recorded suctioning performed was on 6/8/12 by Staff C. Nurse's notes 6/8/12 at 10:40 a.m. written by Staff C indicated Resident #1 with a loose wet cough and Resident #1 suctioned thick clear phlegm present.

In an interview on 8/6/12 at 11:05 a.m. Staff C (Registered Nurse, RN) indicated on 6/22/12 at around 7:00 a.m. she went into Resident #1's room to check for safety alarms. Resident #1 was in bed resting quietly without any signs or symptoms of discomfort. Staff C indicated later that morning she was approached by Family Member (FM) 2 (Resident #1 family member)

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F 456	Continued From page 15	F 456		

while on Hall 1. FM 2 told her that Resident #1 was in need of suctioning and Staff A wouldn't help. Staff C indicated she assumed Staff A, who was assigned to Resident #1, would get her if she needed help. Staff C indicated at around 8:15 a.m. Resident #1 was brought into the assisted dining room by Staff B (CNA). Resident #1 was alert , but gurgling. Staff B attempted to get him/her to cough up the phlegm without success. Staff C instructed Staff B to hold the food, but try to get Resident #1 a sip of tea. Within 2-3 minutes as the gurgling persisted, Staff A entered the assisted dining room and Staff C and Staff D (CNA) took Resident #1 to his/her room. The suction machine in the room was not set up for immediate use. Staff C had to leave the room to obtain a canister, came back to the room to find there was no tubing. Staff C went back to the supply room and obtained tubing. While setting up the canister and tubing, Resident #1 took two deep breathes and then stopped breathing.

In an interview on 8/6/12 at 4:10 p.m. Staff C indicated her understanding of facility protocol regarding suctioning is that the suction machine and all needed equipment be available at bedside and ready for use. Following suctioning the tubing and canister are to be exposed of in a biohazard bag, the suction machine sanitized and new equipment (canister and tubing) restocked.

In an interview on 8/2/12 at 2:40 p.m. Staff D (certified nurse aide, CNA) indicated on 6/22/12 at around 8:15 a.m. she was in the assisted dining room assisting residents with eating when Resident #1 was propelled into the assisted dining room by Staff B (CNA). Staff D indicated she heard Resident #1 choking before he/she

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F 456	Continued From page 16	F 456		

ever got into the assisted dining room. Resident #1 sounded like he/she was drowning. Staff D immediately questioned what was happening and Staff B indicated Resident #1 was pocketing. Staff D indicated that was not pocketing and stated she would find someone to help. Staff C (RN), who was also in the assisted dinning room, stated she would help or Staff A (LPN) could help. At that time Staff A entered the assisted dining room. Staff D instructed Staff A to remain in the assisted dining room and Staff C and Staff D took Resident #1 to his/her room to be suctioned. Staff D indicated Resident #1 was already turning gray as they left the assisted dining room. FM 1 (Resident #1 family member) met Staff C and Staff D in the main lobby and followed them into Resident #1's room. As they prepared to suction they discovered not all the needed items were in the room. Staff C and Staff D left the room to get needed supplies as FM 1 remained with Resident #1. Upon returning Resident #1 was turning even more gray and Resident #1 was stating, "I'm sick, I'm sick, I'm sick". Staff C continued to work on the suction machine then proceeded to suction him/her, but it was too late.

In an interview 8/6/12 at 4:40 p.m. Staff A (registered nurse, RN) indicated the suctioning protocol for the facility includes that following suctioning of a resident, the machine is to be cleaned, the tubing and canister disposed of and the machine restocked with a new canister and tubing for immediate use.

In an interview 8/6/12 at 3:50 p.m. Staff G (assistant director of nursing) indicated the suctioning protocol for the facility includes that the suction machine is stored in the designated area

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F 456	Continued From page 17 and ready for immediate use. Following suctioning of a resident, the used tubing and canister was to be appropriately disposed of, the machine was to be cleaned and new tubing and canister restocked and ready for use. In an interview on 8/6/12 at 6.55 p.m. with Staff L (licensed practical nurse, LPN) she indicated the suctioning protocol for the facility includes that following suctioning of a resident, the machine is to be cleaned, the tubing and canister disposed of and the machine restocked with a new canister and tubing for immediate use. In an interview 8/6/12 at 3:40 p.m., Staff M (director of nursing), indicated she would expect that the suction machine be checked routinely and be ready for immediate emergency use. In an interview 8/6/12 at 7:20 p.m,. Staff N (licensed practical nurse), indicated the suctioning protocol for the facility includes the expectation that the suction machine and all needed supplies are available with the machine and following suctioning of a resident, the machine is to be sanitized, the tubing and canister disposed of and the machine restocked with a new canister and tubing for immediate use.	F 456		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours	F 497		

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F 497	Continued From page 18	F 497		

per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

This REQUIREMENT is not met as evidenced by
Based on record review and staff interview the facility failed to perform yearly performance evaluations for Certified Nurse's Aides employed by the facility. The facility census was reported as 59 residents and the staff CNA sample was eight employees.

Findings include:

1. Record review on 8/27/12 of eight CNA personal files revealed five of the files were lacking yearly performance evaluations reviews including the following:.

Staff E, CNA, was hired by the facility on 5/15/06. Performance evaluations noted in Staff E's personal file were dated 9/15/06, 9/30/08, 9/15/09, and 9/24/10.

Staff F, CNA, was hired by the facility on 10/13/06. A performance evaluation noted in the CNA's personal record was dated 10/26/10.

Staff G, CNA, was hired by the facility on 11/19/10. Two performance evaluations in Staff G's personal file were dated 10/19/10 and 5/2/11.

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F 497	Continued From page 19 Staff H , CNA, was hired by the facility on 9/11/06. Performance evaluations noted in Staff H's personal file were dated 9/15/08, 9/15/09, and 10/4/10. Staff I, CNA, was hired by the facility on 2/13/08. Two performance evaluations noted in Staff I's file were dated 1/3/10 and 2/1/11. During review of personal files Staff B, Director of Nurses (DON), and Staff C, consultant nurse, were unable to produce a policy for staff evaluation and compentency review prior to a new policy recently developed on 8/20/12. During an interview on 8/27/12 at 3 p.m. Staff D, Corporate Nurse, stated on 8/20/12 the administrative staff identified a system breakdown with the process of evaluations of nursing staff when they noted several yearly evaluations and competency reviews were not present in staff files. At that time an action plan was developed to correct the problem and to initiate a policy for evaluations of staff. She stated the administrative staff was unable to determine CNA competency levels without a timely performance evaluation and would be unable to offer appropriate in-services and re-education progtrams.	F 497		

F309

This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and State law.

The preparation of the following Plan of Correction for these deficiencies does not constitute, and should not be interpreted as an admission or an agreement by the facility of the facts alleged, or conclusions set forth in the statement of deficiencies. The plan of Correction was executed solely because provisions of the State and Federal Law require it.

Without waiving the foregoing statement, the facility states that with respect to Resident #`1 and all other similarly situated residents all Licensed Nursing staff has been re-educated relating to facility policy related assessments and timely interpretations.

DON/Consultant Nurse will do random audits with ongoing education.

DON/Consultant Nurse will report to QA Committee monthly for the first 90 days and quarterly thereafter.

F354

This Facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and State law.

The preparation of the following Plan of Correction for these deficiencies does not constitute, and should not be interpreted as an admission or an agreement by the facility of the facts alleged, or conclusions set forth in the statement of deficiencies. The Plan of Correction was executed solely because provisions of State and Federal law require it.

Without waiving the foregoing statement, the facility states that the DON/designee of the Facility will prepare a schedule which will provide RN coverage for 8 consecutive hours a day, seven days a week. The DON hours will be included on the schedule.

The Administrator/designee will review the schedule prior to posting monthly for the first 90 days and randomly thereafter.

QA will review monthly for the first 90 days and quarterly thereafter.

F456

This Facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and State law.

The preparation of the following Plan of Correction for these deficiencies does not constitute, and should not be interpreted as an admission or an agreement by the facility of the facts alleged, or conclusions set forth in the statement of deficiencies. The Plan of Correction was executed solely because provisions of State and Federal law require it.

Without waiving the foregoing statement, the Facility states that with respect to Resident # 1 and all other similarly situated residents, the Facility has educated all Licensed Nursing Staff on the facility policy relating to Suctioning Machine readiness and cleaning.

Licensed Nursing staff will check Suction Machine daily for readiness.

Checklist has been added to daily 24 hour report sheet

QA Committee will review monthly for the first 90 days and quarterly thereafter.

F497

This Facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and State law.

The preparation of the following Plan of Correction for these deficiencies does not constitute, and should not be interpreted as an admission or an agreement by the facility of the facts alleged, or conclusions set forth in the statement of deficiencies. The Plan of Correction was executed solely because provisions of State and Federal law require it.

Without waiving the foregoing statement the Facility will complete a performance review of all CNAs at least once every 12 months, and will provide regular in-service education based on the outcome of the reviews.

An Action Plan was put into place prior to the visit, and submitted to the Surveyors on 8/27/2012, which outlines specific criteria including a timeline for completion of performance evaluations for all employees with at least three months of service to be finalized by 9/30/2012 and spells out an on going systematic approach to consistence in the evaluation of employees.

The DON/Designee will complete performance reviews with every CNA at least an annual basis.

The QA committee will review monthly for the first 90 days and quarterly thereafter.